EXPRESS SCRIPTS®

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

June 29, 2016

VLADIMIR REDKO
6560 FANNIN ST STE 2020
HOUSTON TX 770302736

Dear Provider,

Express Scripts, Inc. and Medco Health Solutions, Inc. (collectively, 'Express Scripts'), a pharmacy benefit Management Company, periodically requests and reviews claims submitted by our network pharmacies. This is done to help identify and investigate potential fraud, waste and abuse.

Enclosed is a listing of prescriptions for one or several of your patients. **We would greatly appreciate it if someone from your staff could review the listings enclosed and verify the authenticity of the prescription claims.**

Please fax your response to me at 800-606-5569.

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**Your prompt response is greatly appreciated.** If you have any questions regarding this request or should you need assistance, please feel free to contact me at the number below.

Sincerely,

Blake Stockwell
Investigator, FWA Services
Express Scripts
One Express Way: Mail Stop HQ2 W03
Saint Louis, MO 63121
Phone: (314) 684-5326 | Fax: (800) 606-5569
bstockwell@express-scripts.com

Enclosure

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: VILA MILOSEVIC** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? _____/_____/_____
- Patient diagnoses : _____
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO**
- If question #4 is YES, when was the agreement signed? _____/_____/_____
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 9/10/2014 | COMPOUND | 300 | | | |

Comm Confidential Information

To the best of my knowledge, all information provided above is true and correct.

**Signature** **Date** **Print Name** **Office Phone**

***Signature is required for authentication purposes.**

PRIVATE & CONFIDENTIAL

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**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: SHEILA BUCKINGHAM** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? ____/____/____
- Patient diagnoses : _____
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO**
- If question #4 is YES, when was the agreement signed? ____/____/____
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/23/2014 | COMPOUND | 300 | | | |

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PRIVATE & CONFIDENTIAL

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June 29, 2016

VLADIMIR REDKO
6560 FANNIN ST STE 2020
HOUSTON TX 770302736

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Enclosure

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: RHONDA SHARON** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? _____/_____/_____
- Patient diagnoses : _____
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO**
- If question #4 is YES, when was the agreement signed? _____/_____/_____
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/29/2015 | COMPOUND | 300 | | | |

Comm Confidential Information

To the best of my knowledge, all information provided above is true and correct.

**Signature** **Date** **Print Name** **Office Phone**

***Signature is required for authentication purposes.**

EXPRESS SCRIPTS®

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June 29, 2016

VLADIMIR REDKO
6560 FANNIN ST STE 2020
HOUSTON TX 770302736

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**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: RYAN DUNKLE** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? ____/____/____
- Patient diagnoses : _____
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO**
- If question #4 is YES, when was the agreement signed? ____/____/____
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/31/2014 | COMPOUND | 300 | | | |
| 10/31/2014 | COMPOUND | 60 | | | |
| 10/31/2014 | COMPOUND | 300 | | | |
| 10/31/2014 | COMPOUND | 60 | | | |

Comm Confidential Information

To the best of my knowledge, all information provided above is true and correct.

**Signature** **Date** **Print Name** **Office Phone**

***Signature is required for authentication purposes.**

EXPRESS SCRIPTS®

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June 29, 2016

VLADIMIR REDKO
6560 FANNIN ST STE 2020
HOUSTON TX 770302736

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Enclosure

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**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: TODD DUNKLE** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? _____/_____/_____
- Patient diagnoses : _____
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO**
- If question #4 is YES, when was the agreement signed? _____/_____/_____
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/31/2014 | COMPOUND | 60 | | | |
| 10/31/2014 | COMPOUND | 300 | | | |
| 10/31/2014 | COMPOUND | 60 | | | |
| 10/31/2014 | COMPOUND | 300 | | | |

Comm Confidential Information

To the best of my knowledge, all information provided above is true and correct.

**Signature** **Date** **Print Name** **Office Phone**

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HOUSTON TX 770302736

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bstockwell@express-scripts.com

Enclosure

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: MICHAEL REDKO** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? _____/_____/_____
- Patient diagnoses : _____
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO**
- If question #4 is YES, when was the agreement signed? _____/_____/_____
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 11/12/2014 | COMPOUND | 120 | | | |
| 11/12/2014 | COMPOUND | 60 | | | |
| 11/12/2014 | COMPOUND | 300 | | | |
| 11/12/2014 | COMPOUND | 60 | | | |

Comm[redacted] Confidential Information

To the best of my knowledge, all information provided above is true and correct.

**Signature** **Date** **Print Name** **Office Phone**

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June 29, 2016

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6560 FANNIN ST STE 2020
HOUSTON TX 770302736

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Enclosure

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: EVAN BUCKINGHAM** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? _____/_____/_____
- Patient diagnoses : _____
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO**
- If question #4 is YES, when was the agreement signed? _____/_____/_____
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/23/2014 | COMPOUND | 300 | | | |

Comm Confidential Information

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**Signature** **Date** **Print Name** **Office Phone**

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Enclosure

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: ALEXA BUCKINGHAM** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? ____/____/____
- Patient diagnoses : _____
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO**
- If question #4 is YES, when was the agreement signed? ____/____/____
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

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| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/23/2014 | COMPOUND | 300 | | | |

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**Signature** **Date** **Print Name** **Office Phone**

***Signature is required for authentication purposes.**

6560 FANNIN, SUITE 2020
HOUSTON, TX, 77030
Phone: 713-790-1400
Fax: 713-790-1499

PAIN AND HEALTH MANAGEMENT CENTER

# Fax

**To:** Blake Stockwell **From:** V. REDFO, M.D.

**Fax:** **Date:** 7/5/16

**Phone:** **Pages:** 9

**Re:**

☐ **Urgent** ☒ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

•**Comments:**

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: ALEXA BUCKINGHAM** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? 9/4/14
- Patient diagnoses : painful scar left arm
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO** N/A
- If question #4 is YES, when was the agreement signed? ____/____/____ N/A
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO** N/A

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/23/2014 | COMPOUND | 300 | PRN | ✓ | |

Comm Confidential Information

To the best of my knowledge, all information provided above is true and correct.

Signature 7/5/16 Date V. REDKO, M.D. Print Name 713-790-1400 Office Phone

***Signature is required for authentication purposes.**

PRIVATE & CONFIDENTIAL

Confidentiality Statement: The documents accompanying this letter contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: EVAN BUCKINGHAM** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
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*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** **NO**
- If question #1 is YES, when was the last time the patient was seen? 9/4/14
- Patient diagnoses : hypertrophic painful scar forehead.
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** **NO** N/A
- If question #4 is YES, when was the agreement signed? ____/____/____ N/A
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) **YES** **NO** N/A

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/23/2014 | COMPOUND | 300 | PRN | V | |

Comm[redacted] Confidential Information

To the best of my knowledge, all information provided above is true and correct.

V. Redko 7/5/16 V. REDKO, M.D 713-790-1400
**Signature** **Date** **Print Name** **Office Phone**

***Signature is required for authentication purposes.**

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: VILA MILOSEVIC** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**

**Please complete all steps below and then sign below the chart.**

*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) (YES) NO
- If question #1 is YES, when was the last time the patient was seen? 1/13/14
- Patient diagnoses : hypertrophic painful scar right knee
- Does this patient have a medication treatment agreement with you? (circle one) YES NO N/A
- If question #4 is YES, when was the agreement signed? ____/____/____ N/A
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) YES NO N/A

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 9/10/2014 | COMPOUND | 300 | PRN | U | |

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To the best of my knowledge, all information provided above is true and correct.

V. Redko 7/5/16 V. REDKO, M.D 713-790-1400

**Signature** **Date** **Print Name** **Office Phone**

***Signature is required for authentication purposes.**

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: MICHAEL REDKO** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) (YES) NO
- If question #1 is YES, when was the last time the patient was seen? 5/17/16
- Patient diagnoses : low back pain (HNP), alopecia, gout
- Does this patient have a medication/treatment agreement with you? (circle one) YES NO N/A
- If question #4 is YES, when was the agreement signed? ____/____/____ N/A
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) YES NO N/A

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 11/12/2014 | COMPOUND | 120 | 11 | V | |
| 11/12/2014 | COMPOUND | 60 | 11 | V | |
| 11/12/2014 | COMPOUND | 300 | 11 | V | |
| 11/12/2014 | COMPOUND | 60 | 11 | V | |

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To the best of my knowledge, all information provided above is true and correct.

V. Redko 7/5/16 V. REDKO, M.D 713-790-1400
**Signature** **Date** **Print Name** **Office Phone**

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**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: SHEILA BUCKINGHAM** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**

**Please complete all steps below and then sign below the chart.**

*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) YES NO
- If question #1 is YES, when was the last time the patient was seen? 9/4/14
- Patient diagnoses : hypertrophic painful scars of abdomen
- Does this patient have a medication/treatment agreement with you? (circle one) YES NO N/A
- If question #4 is YES, when was the agreement signed? ____/____/____ N/A
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) YES NO N/A

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/23/2014 | COMPOUND | 300 | PRN | V | |

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V. Redko 7/5/16 V. REDKO, M.D. 713-790-1400

**Signature** **Date** **Print Name** **Office Phone**

***Signature is required for authentication purposes.**

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**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: RHONDA SHARON** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) **YES** NO
- If question #1 is YES, when was the last time the patient was seen? 7/1/16
- Patient diagnoses : low back pain, failed back surgery syndrome
- Does this patient have a medication/treatment agreement with you? (circle one) **YES** NO
- If question #4 is YES, when was the agreement signed? 10/28/14
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) YES **NO**

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/29/2015 | COMPOUND | 300 | 11 | ✓ | |

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V. Redko 7/5/16 V. REDKO, M.D. 713-790-1400
**Signature** **Date** **Print Name** **Office Phone**

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**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: TODD DUNKLE** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) YES NO
- If question #1 is YES, when was the last time the patient was seen? 4/10/14
- Patient diagnoses : Low back pain, painful tear of knee, hip, neck
- Does this patient have a medication/treatment agreement with you? (circle one) YES NO N/A
- If question #4 is YES, when was the agreement signed? ____/____/____ N/A
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) YES NO N/A

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/31/2014 | COMPOUND | 60 | PRN | V | |
| 10/31/2014 | COMPOUND | 300 | 11 | V | |
| 10/31/2014 | COMPOUND | 60 | PRN | V | |
| 10/31/2014 | COMPOUND | 300 | 5 | V | |

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To the best of my knowledge, all information provided above is true and correct.

V. Redko 7/5/16 V. REDKO, M.D 713-790-1400
Signature Date Print Name Office Phone

***Signature is required for authentication purposes.**

Please Fax Back to: **1-800-606-5569** For Internal use Only: Log # 5907449

**PLEASE READ CAREFULLY. THIS IS NOT A REFILL REQUEST.**

**Patient Name: RYAN DUNKLE** **Patient Date of Birth:** [redacted]

**Dr. VLADIMIR REDKO,**
**Please complete all steps below and then sign below the chart.**
*(The questions apply to you and/or any physician extender(s) under your supervision.)*

- Have you ever seen the above named patient? (circle one) YES NO
- If question #1 is YES, when was the last time the patient was seen? 4/10/14
- Patient diagnoses : Low back pain, hypertrophic scar of fusse
- Does this patient have a medication/treatment agreement with you? (circle one) YES NO N/A
- If question #4 is YES, when was the agreement signed? ____/____/____ N/A
- Are you aware of this patient seeing any additional prescriber(s) for controlled substance medication(s)? (circle one) YES NO N/A

Did you prescribe the claims listed below for the above listed patient? Please indicate by checking 'Yes' or 'No' in the appropriate column *and* indicate number of refills authorized.

**NOTE: The date of fill may not be the date the prescription was written.**

| DATE OF FILL | MEDICATION NAME | QUANTITY PRESCRIBED | # of REFILLS? | AUTHORIZED BY YOU and/or YOUR PHYSICIAN EXTENDER(S)? YES | NO |
|---|---|---|---|---|---|
| 10/31/2014 | COMPOUND | 300 | 11 | ✓ | |
| 10/31/2014 | COMPOUND | 60 | PRN | ✓ | |
| 10/31/2014 | COMPOUND | 300 | 5 | ✓ | |
| 10/31/2014 | COMPOUND | 60 | PRN | ✓ | |

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V. Redko 7/5/16 V. REDKO, M.D. 713-790-1400
**Signature** **Date** **Print Name** **Office Phone**

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